



Elk Hill _____ Application for Admission

Name of Youth: _____ Nickname: _____
Last *First* *Middle*

Date of Birth: _____ Place of Birth: _____

Youth's Social Security Number: _____ Race: _____

Sex: Male Female Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Marks, Scars, Tattoos: _____

Allergies: _____ Medication Allergies: _____ Other: _____

Last Known Address: _____

Religious Preference: _____

Legal Guardian: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Father's Name: _____
Last *First* *Middle*

Address: _____

Social Security Number: _____ Date of Birth: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: _____ Stepmother's Name: _____

Mother's Name: _____
Last *First* *Middle*

Address: _____

Social Security Number: _____ Date of Birth: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: _____ Stepfather's Name: _____

Please list brothers or sisters of youth. Identify step and/or half siblings and specify birth dates.

	Name	Relationship	Birthdate	Address
1.				
2.				
3.				
4.				



Emergency Contact Information

Contact Person: _____ Phone Number: _____
Address: _____

Agency Information

Local Educational Agency: _____
Address: _____
Contact Person: _____ Phone Number: _____
Fax Number: _____ email: _____ Cell Phone: _____
Youth's Grade: _____ Is Youth Special Education Yes No Special Education Designation: _____
FSIQ: _____ Current School Status: Attending Truant Home School Expelled/Suspended
Estimated Intellectual/Functional Capacity: above average average below average diagnosed MR
Educational Needs: _____

Base School: _____
Contact Person: _____ Phone Number: _____
Fax Number: _____ email: _____

Social Services Agency (if applicable): _____
Address: _____
Contact Person: _____ Phone Number: _____
Supervisor: _____ Phone Number: _____
Fax Number: _____ email: _____ Cell Phone: _____

Juvenile Court Services Agency (if applicable): _____
Address: _____
Contact Person: _____ Phone Number: _____
Fax Number: _____ email: _____ Cell Phone: _____
Please list legal charges, dates obtained, and disposition of charges: _____



Placement Reasons

Reason for Placement (description of problem behaviors in the past 30 days): _____

Please list last two placements and reasons why discharged _____

Please identify feelings this youth struggles with managing effectively: _____

Please identify stressors that provoke this youth: _____

Please identify interventions that work well in deescalating this youth: _____

Identifying Problems *(Please check all that apply)*

- | | | | |
|------------------------------|--------------------------|-------------------------------|--------------------------|
| Verbal aggression/disrespect | <input type="checkbox"/> | Irritability/Mood Swings | <input type="checkbox"/> |
| Physical Aggression | <input type="checkbox"/> | Psychological/Psychiatric | <input type="checkbox"/> |
| Stealing/Shoplifting | <input type="checkbox"/> | Poor/Low Academic Performance | <input type="checkbox"/> |
| Absconding/Runaway | <input type="checkbox"/> | Self-destructive behaviors | <input type="checkbox"/> |
| Lying | <input type="checkbox"/> | Low Motivation | <input type="checkbox"/> |
| Substance Abuse | <input type="checkbox"/> | Peer Relationships | <input type="checkbox"/> |
| Family Relationships | <input type="checkbox"/> | | |

Current Medications:

Name	Dose	Schedule	Length of Time Taken

Recent Medication Changes Y N (if yes explain) _____

Has the youth complied with recommended medication and treatment plans? Y N (if yes explain) _____

DSM-IV Diagnosis

- Axis I _____
- Axis II _____
- Axis III _____
- Axis IV _____
- Axis V _____



Insurance Information

Primary Insurance

Insurance Company: _____

Policy#: _____ Group#: _____

Insurance Company's Telephone Number: _____

Employer's Name and Address: _____

Does this policy include:

Dental coverage? Yes No

Prescription Yes No

Vision Yes No

(You must provide a copy of insurance cards)

Secondary Insurance (if applicable)

Insurance Company: _____

Policy#: _____ Group#: _____

Insurance Company's Telephone Number: _____

Does this policy include:

Dental coverage? Yes No

Prescription Yes No

Vision Yes No

(You must provide a copy of insurance cards)

I am confirming that _____ has active health insurance. I understand that Elk Hill must have a copy of this card immediately. I will also provide any updated insurance information if insurance coverage changes. An Elk Hill sanctioned physician has my permission to treat patient and file claim to my insurance carrier. I understand that if services rendered are not covered, I am responsible for payment of those services.

Signature

Printed Name

Date



Required Attachments

Copy of FAPT service/treatment plan

No Record Available

Comment: _____

Copy birth certificate

No Record Available

Comment: _____

Social History

No Record Available

Comment: _____

Copy social security card

No Record Available

Comment: _____

Psychological evaluation

No Record Available

Comment: _____

Most recent school transcript

No Record Available

Comment: _____

Copy of Medicaid card or other Active Health Insurance

No Record Available

Comment: _____

Current IEP and Eligibility minutes

No Record Available

Comment: _____

Immunization Record

No Record Available

Comment: _____

Educational evaluation and test scores

No Record Available

Comment: _____

Therapist recommendation if stepping down from higher level of care

Letter of program completion, or Psychosexual, or Risk Assessment (Sex Offenders)

Dental Exam Date: _____

Physical Exam Date: _____

Person Submitting Application:

Signature

Printed Name

Date of Application

Work Phone _____ **Fax** _____

Email _____